Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COLUMBIA RIO GRANDE REGIONAL HOSPITAL
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-99-1276-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier simply adopted the rates and asserted the payment was fair and reasonable with no substantiating support or evidence for the same. Merely adopting a fee guideline, which has been held unenforceable by the Supreme Court of Texas by no means establishes what is fair and reasonable. In light of the above the provider asserts it is owed the full amount of the bill, which is fair and reasonable…In light of the above the provider asserts it is owed the full amount of the bill, which is fair and reasonable. At the least the carrier owes 80% of the total charges pursuant to the 'old law'."

Amount in Dispute: $4,522.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester has failed to meet its burden to show that the reimbursement received was insufficient under the requirements of the Texas Labor Code. Therefore, Carrier requests a determination that the requester is not entitled to further reimbursement for the date of service at issue."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 1997 to October 2, 1997	Inpatient Hospital Services	$4,522.70	$0.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on August 20, 1998.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – THE CARRIER HAS ADOPTED THE PER-DIEM AS FAIR AND REASONABLE

Findings

1. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Review of the submitted documentation finds that the length of stay was 2 days. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 2 days yields a reimbursement amount of $2,236.00. This amount less the amount paid by the insurance carrier of $2,236.00 leaves an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	November 21, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.